Approved
9/26/18
SHN

Charlotte Hungerford Hospital
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September 21, 2018

Susan H. Newton, RN, BS
Supervising Nurse Consultant
Department of Public Health
Facility Licensing Investigation Section
410 Capitol Avenue, MS #12 FLIS
P.O. Box 340308
Hartford, CT 06134-0308

Dear. Ms. Newton:

Enclosed please find the Charlotte Hungerford Hospital's response to the letter of violation dated September 10, 2018.

Should you have any questions or require additional information, I can be reached at 860-496-6611 or at pscalise@hhchealth.org. Kate Betancourt, Director of Quality, can be reached at 860-496-6347 or at kbetancourt@hchhealth.org.

Sincerely,

Paul Scalise, MD
Vice President of Medical Affairs

Charlotte Hungerford Hospital
Plan of Correction for
Violation Letter Dated September 10, 2018

Tag/Violation	Defined Measures to Prevent Reoccurrence	Completion Date
Violation # 1a: The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Service (1) and or General (6). *Based on a clinical record review, facility documentation and interviews for one of three sampled patients receiving oxygen in the ED, the hospital failed to ensure that a portable oxygen tank had a sufficient amount of oxygen for patient use resulting in a change in the patient's oxygen saturation level requiring intubation.	**Responsible person:** Vice President of Patient Care Services **Action Items/Implementation Plan:** **Immediate Actions:** 1. On 7/23/18, communication was sent by the Administrative Director of Nursing to all Emergency Department RNs reinforcing that when administering oxygen via a portable tank to patients in the Emergency Department: a. Always utilize a new, full tank b. Admit patient to a treatment room as soon as possible c. Reassess oxygen tank status frequently 2. On 7/24/18, Interim Guidelines for Use of Portable Oxygen Tanks in the Emergency Room Department were developed, with a mandatory acknowledgement/sign-off required. 3. On 7/25/18, the identified issue was reviewed at the Quality Assessment and Performance Improvement Committee meeting. 4. On 7/31/18 during the organizational daily safety huddle, a Safety Alert re: monitoring oxygen tank status was reviewed with all leaders in attendance. 5. On 7/31/18, an email was sent to clinical leadership with a written safety alert on oxygen tank monitoring, as well as hospital policy for transporting patients with oxygen, for review and forwarding to their teams. The alert included a job aide to assist clinical staff in gauging the length of time an oxygen tank will last, based on delivery flow rate. 6. On 8/1/18, hard copies of the Safety Alert were provided to leadership during daily safety huddle with instructions to review the alert during unit-based huddles and to post in staff areas. 7. On 8/6/18 the identified issue was reviewed at the Medical Executive Committee. **Additional Actions:** 1. Policy # 100.016, Transporting Patients with Oxygen, will be updated to include expectations regarding verification and monitoring of tank status. 2. On 9/26/18, the identified issue will be reviewed at the Board of Directors meeting.	7/23/18 7/24/18 7/25/18 7/31/18 7/31/18 8/1/18 8/6/18 9/21/18 9/26/18

Tag/Violation	Defined Measures to Prevent Reoccurrence	Completion Date
	3. A mandatory HealthStream module on oxygen safety, including revised policy language for tank status verification, will launch on 10/1/18. Training completion date will be 12/3/18	12/3/18
	Ongoing Monitoring Plan: 1. Starting in October 2018, 5 random weekly audits will be conducted by the Respiratory Therapy team to confirm that: a. Oxygen tank storage is consistent with policy (proper segregation of full/post use oxygen tanks) b. Oxygen tank status is adequate for patient need and being monitored by personnel when in use. 2. Weekly audits will continue until 4 consecutive weeks demonstrate 100% compliance on both parameters. Thereafter, quarterly audits will be conducted x two to confirm that performance is sustained.	10/31/18 Ongoing
	Where Reported: 1. Results will be reported out at the QAPIC meetings until auditing concludes.	Ongoing
Violation # 2a: The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2). Based on a clinical record review, facility documentation and interviews for one of three patients reviewed for grievances, the facility failed to ensure efforts were made to provide a resolution.	**Responsible person:** Director of Patient Experience **Action Items/Implementation Plan:** **Immediate Actions:** 1. On 5/25/18, the Director of Patient Experience met with staff and reviewed expectations to provide an interim update or to close grievances regardless of pending communication from the patient or his/her representative. 2. On 7/23/18, the preliminary finding from DPH related to delayed closure of a grievance was reported to the QAPIC and recommendation was made to report metrics on timely grievance closure to QAPIC on a monthly basis. 3. As of 8/22/18, the metric "percent of grievances closed within 30days" was added to the standing regulatory report. **Additional Actions:** 1. Starting the week of 9/24/18, a weekly review process will be initiated to confirm closure (or interim communication) on any grievance due for closure within the subsequent 7 days. A tracking log will be utilized to capture the review process.	5/25/18 7/23/18 8/22/18 9/24/18

Tag/Violation	Defined Measures to Prevent Reoccurrence	Completion Date
	Monitoring: 1. Monthly review of percent grievances closed within 30 days will be continued until 3 consecutive months of ≥ 100% compliance has been sustained. Thereafter, 2. Quarterly audits will be performed and reported to QAPIC. **Where reported:** 1. CHH QAPIC, minutes of which are submitted to the Northwest Regional Board of Directors 2. CHH Grievance Committee	Ongoing Ongoing